EXAMPLE - A

Reach Out and Read Sample Workplan

Florida Healthy Babies Initiative

Objective: By December 31, 2018, reduce the annual black infant mortality rate from 11.4 (2015) to 8.3 per 1,000 live births.

Objective: By December 31, 2018, reduce black-white infant mortality gap from 2.6 (2015) to less than two times higher.
State Performance Measure: The percentage of parents who read to their young child age 0-5 years

Lead: XXX County Health Department

Strategic Issue Area: Reduce racial disparity in infant mortality.

Goal: Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

Education plays a major role in a person's overall health and well-being throughout their lifetime and is linked to healthy behaviors, higher income, sustained employment and improved health outcomes. Particularly important, early education establishes the foundation for a healthy life. The American Academy of Pediatrics Policy Statement 2014: *Literacy Promotion: An Essential Component of Primary Care Pediatric Practice* states "Reading regularly with young children stimulates optimal patterns of brain development and strengthens parent-child relationships at a critical time in child development, which, in turn, builds language, literacy, and social-emotional skills that last a lifetime. Pediatric providers have a unique opportunity to encourage parents to engage in this important and enjoyable activity with their children beginning in infancy. Research has revealed that parents listen and children learn as a result of literacy promotion by pediatricians, which provides a practical and evidence-based opportunity to support early brain development in primary care practice."

Research shows that when pediatricians promote literacy readiness there is a significant effect on parental behavior and attitudes toward reading aloud, as well as improvements in the language scores of young children who participate. The body of independent, peer-reviewed and published research supporting the efficacy of the Reach Out and Read (ROR) model is more extensive than for any other psychosocial intervention in general pediatrics. Parents who are served by ROR are: 2.5x more likely to read to their children; 2x more likely to read to their children more than 3x a week; families are 2.5x more likely to enjoy reading together or have books in the home; children's language development is improved by 3-6 months; children's language ability improves with increased exposure to ROR. Additionally, evidence shows that ROR changes child outcomes, and results in better primary care. The strategy below seeks to set a foundation for lifetime positive choices (through medical provider and parent partnerships) to promote education/literacy, and should be implemented in areas of high need.

Strategy: Provide leadership for developing a Reach Out and Read and community-wide approach to promoting literacy in underserved communities.
Resource: Reach Out and Read program - http://www.reachoutandread.org/
Resource: American Academy of Pediatrics – Evidence supporting early literacy - https://www.aap.org/en-us/literacy/Pages/Supporting-Evidence.aspx

Indicator	Baseline	Status	Data Source	Progress Comments
1. The percentage of parents who read to their young child age 0-5 years 2. Number of medical staff trained on Reach out and Read 3. Number of community programs implemented that involved literacy 4. Number of medical providers who counsel parents about enjoyable and developmentally appropriate shared-reading activities 5. Number of parents who receive developmentally-appropriate books at health supervision visits **6.** Number of children (5yr olds) who used ROR and are "school-ready" when they begin kindergarten. **7.** Number of meetings with trained providers and local partners				

Activities/Action Steps	Responsible Organization(s)	Completion Date	Status	Progress Comments *Describe progress, barriers, successes*
2. Determine a point of contact within the existing CHD staff to be the the lead Reach Out and Read Coordinator at the CHD.				
3. Seek training and guidance for staff from Reach Out and Read on implementing a program within your CHD.				
4. Reach out to the Ounce of Prevention Fund of Florida for supplemental assistance in obtaining culturally and age approproiate books for distrubition at no charge. https://www.ounce.org/index.asp				

5. Create a reading corner in your facility to encourage reading while waiting for services. Ask staff to model reading in the waiting room to encourage participation with children and families.				
6. Facilitate meetings with other community groups/agencies to help promote awareness, expansion, and benefits of the Reach Out and Read program.				
7. Seeks ways to encourage book donations from community organizations such as Kiwanis, fraternites and sororities, Lions Club, etc.				
8. Arrange local library participation in CHD events or bookmobile events in high need areas.				

EXAMPLE – B

Best Babies Zones Sample Workplans

Florida Healthy Babies Initiative

Objective: By December 31, 2018, reduce the annual black infant mortality rate from 11.4 (2015) to 8.3 per 1,000 live births.

Objective: By December 31, 2018, reduce black-white infant mortality gap from 2.6 (2015) to less than two times higher.

Lead: XXX County Health Department

Strategic Issue Area: Reduce racial disparity in infant mortality.

Goal: Address the local built environment and social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies to improve and sustain a healthier and safer community.

Too many babies in the U.S. are dying at birth or in their first year, at a rate that is higher than almost any other developed nation. These negative effects are not equitably distributed throughout our population, with communities of color experiencing disproportionately higher rates of infant mortality, preterm birth, and low birth weight. As we have seen, traditional health care approaches alone have not been successful in addressing these racial and economic disparities. Drawing from the **Life Course Theory**, Best Babies Zone (BBZ) recognizes that birth outcomes are related to the lived experiences of where we live, work, and play, from one generation to the next. To create lasting change that improves the health of babies over time, we believe a bold, outside-the-box approach is needed.

The Best Babies Zone (BBZ) Initiative is a place-based, multi-site, multi-sector approach to reducing disparities in infant mortality and birth outcomes by mobilizing community residents and organizational partners to address the social and economic determinants of health.

Strategy: Provide leadership for implementing the Best Babies Zone approach in underserved communities.
Resource: http://www.bestbabieszone.org/

Indicator	Baseline	Status	Data Source	Progress Comments
1. Percent of population 25 years or older with no high school diploma 2. Percent of population for whom housing is 30% or more of household income 3. Percent of population 16 years or older currently unemployed 4. Percent of housing units currently				

vacant 5. Percentage of children under 18 years in households headed by a single parent 6. Percent of children age 3-4 enrolled in preschool				
Activities/Action Steps	**Responsible Organization(s)**	**Completion Date**	**Status**	**Progress Comments** *Describe progress, barriers, successes*
1. Participate in an introductory informational call led by Best Babies Zone to learn more about the initative. Select a zone that demonstrates a need to address health inequities in birth outcomes and local organizational capacity to support the BBZ approach. The zone will be a small geographically defined area that has a minimum of 100 births per year and a population ranging from 8,000 to 20,000. (If your county does not meet the eligibility criteria for a BBZ, these action steps can still be taken to as a means to improve the built environment).				
2. Build a multi-sector collaborative that engages partners across four key sectors: economic development, community systems and services, health systems and education and early care.				
3. Identify a Backbone Organization (CHD). This organization should be a trusted organization that will be the coordinator of the initiative. This includes convening partners, tacking progress, and implementing programs				

and strategies.				
4. The Backbone Organization (CHD) will begin to convene partners to form the BBZ team. The core team should include leadership representing the following groups: - Residents - A community-based organization - The local health department - At least one non-health organization				
5. Identify a local champion. This person will be someone who is a strong champion for social change. They are often a leader within the Backbone Organization (CHD Admn.); they have trust and influence in the community; they are committed to the project; and have a passion for health equity.				
6. Engage community members who live in the zone to work with the collaborative to determine what the perspective, priorities and necessary partnerships will be to address health inequities. Methods for engaging community members could be group meetings, one on one conversations, topic specific forums or another method that has shown to be effective in the community.				
7. Give participating community members a specific role that will help them to feel included and valued in the effort.				
8. Engage with national and global social movements with which BBZ is aligned and apply to the community identified prioritites. Some examples may be health equity, racial justice and equity, universal human rights, or reproductive				

justice.				
9. Develop an implementation plan that will be used to identify and sustain the efforts of the collaborative in the BBZ. This includes identifying the mission, vision and values for the local BBZ.				
10. Determine who will design and conduct the evaluation and develop an evalution plan that will involve residents. Involve residents in as many aspects of the evalution as possible.				
11. Secure Institutuional Review Board approval prior to conducting primary data collection in communities.				

EXAMPLE – C

FRESH ACCESS BUCKS Sample Workplan

Florida Healthy Babies Initiative

Objective: By December 31, 2018, reduce the annual black infant mortality rate from 11.4 (2015) to 8.3 per 1,000 live births.

Objective: By December 31, 2018, reduce black-white infant mortality gap from 2.6 (2015) to less than two times higher.

Lead: XXX County Health Department

Strategic Issue Area: **Improve Preconception Health**

Goal: Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

Although prenatal care may improve birth outcomes, the persistent racial disparity in adverse birth outcomes among women who receive adequate prenatal care suggests that a singular focus on this time period is too narrow. By the time women are pregnant, it may be too late to modify important health behaviors, treat chronic illnesses, and address the impact of lifelong underserved minority status. From a policy perspective, a broad focus on the health of African-American women from early life until adulthood represents critical periods for a range of risk factors (i.e., low birthweight), behaviors (i.e., family planning), and exposures (i.e., nutrition) that influence reproductive outcomes. The strategy below seeks to build community and should be implemented in areas of high need.

Strategy: **Improve access to high-quality fruits and vegetables and/or increase the availability of high-quality fruits and vegetables in underserved communities.**

Resource: http://www.foginfo.org/our-programs/fresh-access-bucks/
Resource: http://www.foginfo.org/our-programs/fresh-access-bucks/fab-markets/
Resource: https://www.cdc.gov/obesity/downloads/fandv_2011_web_tag508.pdf "CDC Guide of Strategies to Prevent Obesity and Other Chronic Diseases"
Resource: http://www.changelabsolutions.org/sites/default/files/documents/Getting_to_Grocery_FINAL_20120514.pdf

Indicator	Baseline	Status	Data Source	Progress Comments
1. Number of retail stores that sell high-quality fruits and vegetales in the community prior to intervention 2. Number of meetings with a local or regional food policy council	1. Number of retail stores that sell high-quality fruits and vegetales in the community prior to intervention	At the end of the first year of the program: 1. Number of retail stores that sell high-quality fruits and vegetables 2. Number of meetings held		
Activities/Action Steps	**Responsible Organization(s)**	**Completion Date**	**Status**	**Progress Comments** *Describe progress, barriers, successes*
9. Determine if there is a Fresh Access Bucks (FAB) participating vendor in your community.				
10. Reach out to Farmers Markets, Community Supported Agricultural Shares, Farm Stands and mobile markets to determine interest in becoming a (FAB) vendor.				
11. Determine the capacity for an interested vendor to accept SNAP benefits.				
12. Partner with the Florida Organic Growers organization to assist interested vendors in becoming approved SNAP benefit locations.				
13. Assist interested organizations with completing and submitting the (FAB) application.				
14. Increase public awareness of the FAB program and participating vendors through advertisement methods that have proven to be effective in the community.				

EXAMPLE – D
PACE EH Sample Workplan
Florida Healthy Babies Initiative

Objective: By December 31, 2018, reduce the annual black infant mortality rate from 11.4 (2015) to 8.3 per 1,000 live births.

Objective: By December 31, 2018, reduce black-white infant mortality gap from 2.6 (2015) to less than two times higher.

Lead: XXX County Health Department

Strategic Issue Area: Reduce racial disparity in infant mortality.

Goal: Address the local built environment and social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies to improve and sustain a healthier and safer community.

Although prenatal care may improve birth outcomes, the persistent racial disparity in adverse birth outcomes among women who receive adequate prenatal care suggests that a singular focus on this time period is too narrow. By the time women are pregnant, it may be too late to modify important health behaviors, treat chronic illnesses, and address the impact of lifelong underserved minority status. From a policy perspective, a broad focus on the health of African-American women from early life until adulthood represents critical periods for a range of risk factors (i.e., low birthweight), behaviors (i.e., family planning), and exposures (i.e., nutrition) that influence reproductive outcomes. The strategy below seeks to build community and should be implemented in areas of high need.

Strategy: Implement Protocol for Assessing Community Excellence in Environmental Health (PACE EH) in communities of high need to assess neighborhood and community identified social determinants of health needs and provide action plans to address the top issues as defined by the communities.
Resource: https://www.cdc.gov/nceh/ehs/docs/factsheets/pace_eh_ceha.pdf

Indicator Examples	Baseline	Status	Data Source	Progress Comments
3. Number of manufacturing plants or retail stores brought under code compliance. 4. Number of city water installations made available to homes with no hook-up fee 5. Number of community parks remodeled with children's playground 6. Number of boarded buildings or crack houses demolished				

7. Number of homes built by Habitat for Humanity 8. Number of streetlights installed **9.** Number of meetings with local or regional planners				
Activities/Action Steps	**Responsible Organization(s)**	**Completion Date**	**Status**	**Progress Comments** *Describe progress, barriers, successes*
15. Select a zip code based on a needs assessment, data or other process as determined by the CHD. Use information obtained during initial phase of Florida Healthy Babies including data collected and town hall/community meetings.				
16. Engage staff and community partners outside of typical maternal and child topic area to participate in addressing community need. Example: police department, county utilities such as water and sewer, street lighting, parks and recreation, housing authority, etc.				
17. Assemble a team of partners to do a walk/drive through of the zip code area to assess problems such as failing septic systems/wells, neglected community parks, no sidewalks/street lights, pollution from nearby manufacturing plants, illegal drug activity, food access, check cashing offices, pawn shops, alcohol sales, boarded up buildings, etc.				
18. Facilitate community meetings with partners, faith based leaders to help engage residents and others, etc.				
19. Set-up a process to address the issues.				
20. Support efforts to inform decision makers about the health benefits of improving the built environment.				